Inside This Issue of JACC

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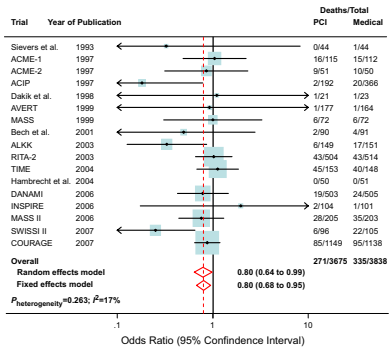

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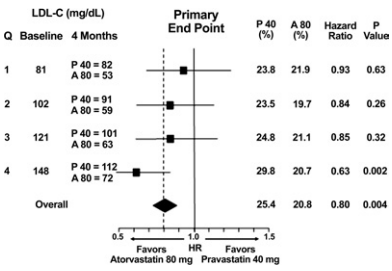

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State-of-the-Art Paper

PCI for Stable CAD

Although percutaneous coronary intervention (PCI) can improve quality of life, there is little evidence of a benefit on hard clinical outcomes. In this article, Katritsis and Meier review the literature and suggest that certain indications for PCI are associated with improved outcomes: patients with significant inducible ischemia, particularly in the context of a recent myocardial infarction, lesions associated with reduced fractional flow reserve, and specific angiographic features of coronary stenoses. They caution that operators should take into account long-term outcomes of techniques rather than immediate angiographic results. **See page 889.**

Interventional Cardiology

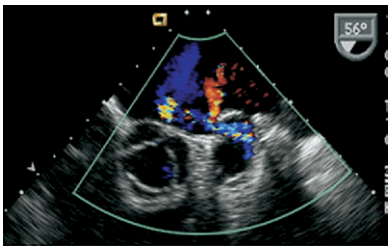
Meta-Analysis Suggests Mortality Benefit for PCI in Patients With Stable CAD

Although several studies have proven that percutaneous coronary intervention (PCI) reduces symptoms in patients with stable coronary artery disease (CAD), no study has clearly demonstrated a mortality benefit, possibly because the studies were too small. Schömig and colleagues performed a meta-analysis of 17 trials that randomized patients to invasive treatment with PCI or medical therapy in over 7,000 patients with demonstrable ischemia, but no recent unstable syndromes. Subjects were followed for at least 1 year. Allocation to PCI was associated with a 20% relative reduction in all-cause mortality; there were also nonsignificant reductions in cardiac death and myocardial infarction. These findings suggest that a PCI-based invasive strategy may improve long-term survival in patients with stable CAD and demonstrable ischemia. **See page 894. See figure.**

Lipid-Lowering Therapy

Less Benefit for Aggressive Lipid Lowering in Patients With Low Baseline LDL-C

While aggressive lipid lowering reduces cardiac risk in broad cohorts of patients, the relative benefit may be reduced or absent in patients with low baseline low-density lipoprotein cholesterol (LDL-C). Giraldez and colleagues reviewed data from the PROVE IT–TIMI 22 trial. For this analysis, only patients who were not taking statins at presentation were included. A significant reduction in the primary end point (hazard ratio: 0.63) occurred in patients within the highest quartile (>132 mg/dl) of baseline LDL-C, but there was no statistical benefit in the lowest quartile (LDL-C <92 mg/dl) (hazard ratio: 0.93). When analyzing LDL-C as a continuous variable, 80-mg atorvastatin was associated with improved outcomes for baseline LDL-C >66 mg/dl, suggesting a threshold below which further LDL-C reduction may not add clinical benefit. **See page 914. See figure.**



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Cardiac Surgery

Low Surgical Success for LAA Closures

Surgical closure of the left atrial appendage (LAA) may reduce the risk of embolic events in patients with atrial fibrillation, but the methods for closure have not been standardized. Kanderian and colleagues reviewed 137 transesophageal echocardiograms (TEEs) performed in patients who had previously undergone LAA closure. The TEEs were performed for clinical indications and occurred an average of 8 months after surgery. Only 40% of closures were successful. Excisional techniques were more successful (73%) than suture exclusion (23%) or stapler exclusion (0%). Thrombus was present in 41% of unsuccessful LAA exclusions, but not in patients with surgical excision. There is a high occurrence of unsuccessful surgical LAA closure. Of the various surgical techniques, excision is the most successful. **See page 924. See figure.**